

11804

CERTIFICATE OF DEATH

11786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Virginia</u> b. COUNTY <u>?</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>				c. LENGTH OF STAY IN TB <u>25yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanoverville</u> 178-1			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Blue</u> Last <u>Blue</u>				4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-12-02</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR: Months <u>5</u> Days <u>17</u> Hours <u>17</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>SARAH BLUE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>John Butler Grasonville, Md</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion (one hour)</u> <u>Oct. 16, 1959</u> DUE TO (b) <u>hypertensive Cardio-vascular disease</u> <u>about 3 yrs</u> DUE TO (c) <u>diabetes mellitus Arteriosclerosis</u> <u>about 4 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at</u>	
20f. (City or town) <u>St</u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>May 11</u> , 19 <u>55</u> , to <u>Oct 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 16</u> , 19 <u>59</u> , and that death occurred at <u>1:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.				ADDRESS (Street, city or town, state) <u>Stevensville Md.</u> DATE SIGNED <u>Oct 16, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER</u>				STEVENSVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grasonville, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Grasonville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel DeWitt, Easton Md.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>OCT 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

11284

Handwritten entries on a lined form, including fields for name, age, sex, date of death, and cause of death. The text is mostly illegible due to fading and bleed-through.

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11805 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u> c. LENGTH OF STAY IN 1b <u>3 week</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Casceen Joe CARTER</u>				4. DATE OF DEATH Month Day Year <u>OCT 5 1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>COL.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>SEPT. 14 - 1959</u>		9. AGE (In years less birthday) yrs. <u>21</u> IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEONARD CARTER</u>				14. MOTHER'S MAIDEN NAME <u>GLADYS WINSTON</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>LEONARD CARTER CHESTER</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Anoxemia</u> 9240 DUE TO <u>Suffocation by bed covering</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>15 min</u> DUE TO (c) <u>15 min</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Infant became entangled in bedding</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>10-11</u> a.m. <u>Oct 4 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Chester</u> (County) <u>QA</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>C. R. Layton</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>C. R. Layton</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10-6-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Oct 5</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL COL.</u>		22d. LOCATION (City, town, or county) <u>CHURCH HILL</u> (State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgard. Kane</u> ADDRESS <u>Church Hill</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF ARIZONA
OFFICE OF THE ATTORNEY GENERAL
PHOENIX, ARIZONA

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11788

11806

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Elsie</u> First <u>Rebecca</u> Middle <u>Green</u> Last				4. DATE OF DEATH <u>October</u> Month <u>26</u> Day <u>1959</u> Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1886</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min.	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Sara Elizabeth Chairs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u> </u>		17. INFORMANT <u>Medford Green</u> Address <u>Church Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Chronic Tumor</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension in Vetting</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Oct 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 24</u> , 19 <u>59</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. Netealfe</u>				ADDRESS (Street, city or town, state) <u>Sudlersville, Md.</u> DATE SIGNED <u>10/27/59</u>			
PHYSICIAN'S NAME (Type) <u>C. H. Netealfe</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>Oct. 28</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Church Hill Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11807

CERTIFICATE OF DEATH

11789

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EVA</u> First <u>DUDLEY</u> Middle <u>MERRICK</u> Last		4. DATE OF DEATH Month <u>Oct</u> Day <u>2</u> Year <u>1954</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24-1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postoffice clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>Sunderville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Merrick</u>		14. MOTHER'S MAIDEN NAME <u>Lida Benson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-26-8848</u>	
17. INFORMANT <u>Lillian Merrick</u>		Address <u>Sunderville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> <u>Jan. 1954 - Oct. 1954</u> <u>(5 years)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 5, 1954</u> , to <u>October 2, 1954</u> , that I last saw the deceased alive on <u>October 2, 1954</u> , and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John R. Smith, Jr.</u>		ADDRESS (Street, city or town, state) <u>Centerville, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>JOHN R. SMITH, JR.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>OCT 5-1954</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sunderville</u>	22d. LOCATION (City, town, or county) (State) <u>Sunderville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Harold Smith of Baltimore</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>John R. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple horizontal lines for text entry, including fields for name, date, and cause of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11790

11808

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Ann MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Ann			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Gertrude Middle Nicklas Last Nicklas				4. DATE OF DEATH Month Oct. Day 7 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1868	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months 13 Days 4 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Gertrude Leach Millington Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 334x DUE TO Gen. Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 13 years DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility History of previous stroke							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Oct. Day 7 Year 19 59 Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) working	
20f. (City or town) Millington (County) (State)							
21. I certify that I attended the deceased from Oct 7 , 19 59 , to Oct 7 , 19 59 , that I last saw the deceased alive on Oct 7 , 19 59 , and that death occurred at 6 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. H. Hamilton				DATE SIGNED 10/8/59			
PHYSICIAN'S NAME (Type) H. H. HAMILTON				ADDRESS (Street, city or town, state) Millington Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10, 1959		22c. NAME OF CEMETERY OR CREMATORY Townsend Cemetery		22d. LOCATION (City, town, or county) (State) Townsend Del.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Yellow ADDRESS Millington Md.				24. REGISTRAR'S SIGNATURE Arthur Williams		24b. REGISTRAR'S SIGNATURE	

11809

CERTIFICATE OF DEATH

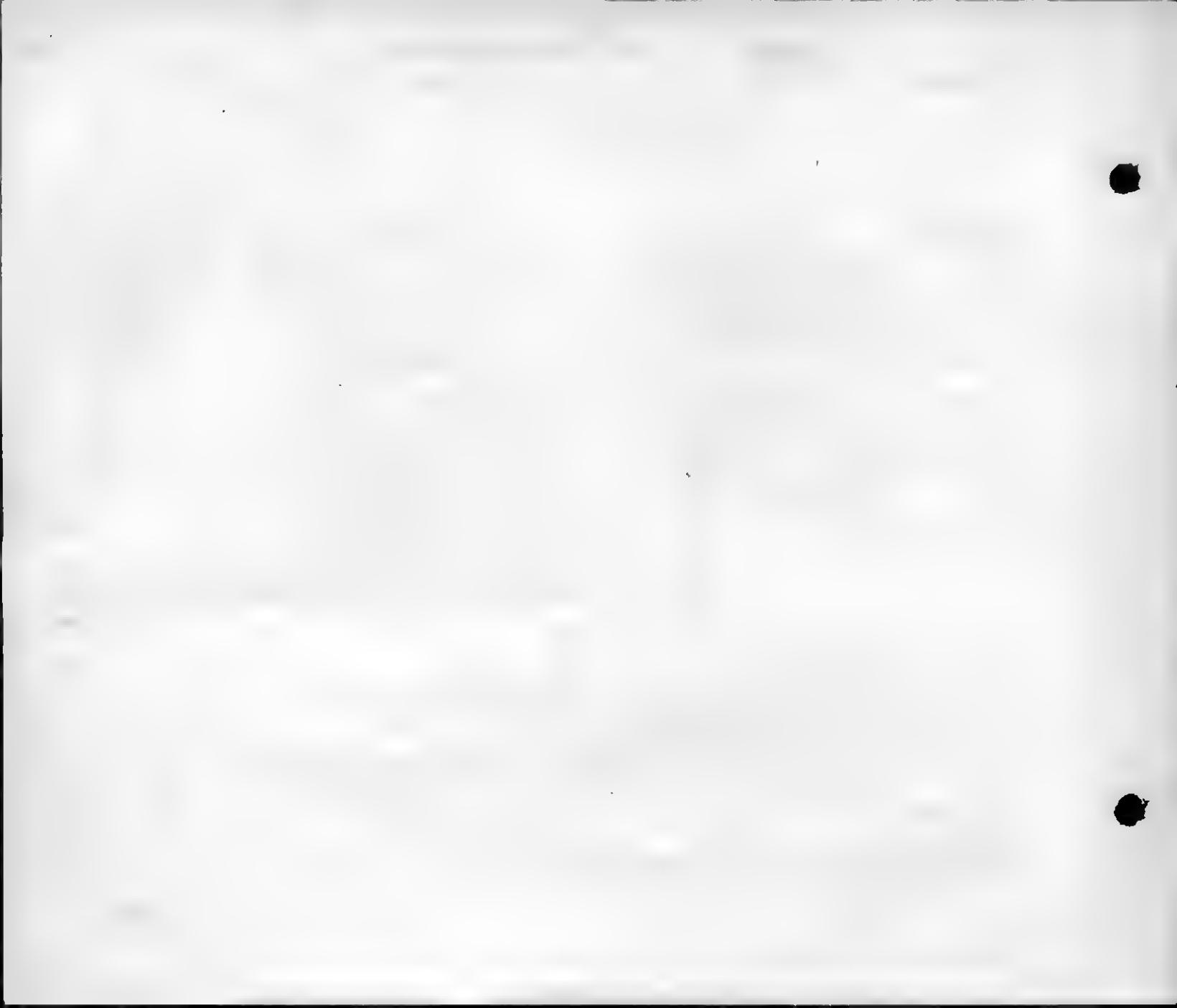
Reg. Dist. No.

11791

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pond Town</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Stevensville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Won Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Pierce</u> Middle Last		4. DATE OF DEATH <u>Oct.</u> <u>4</u> 1959	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/19/82</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert Pierce</u>		14. MOTHER'S MAIDEN NAME <u>Susie Clayton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Maude Johns</u>		Address <u>Stevensville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line of (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x</u> DUE TO <u>Diabetic Gangrene of Foot</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> (c) <u>General Arterio Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m. <u>7:15</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 4</u> , 19 <u>57</u> , to <u>Oct 4</u> , 19 <u>59</u> ; that I last saw the deceased alive on <u>Oct 2</u> , 19 <u>59</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. D. [Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>Stevensville, Md.</u> DATE SIGNED <u>10/5/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baths Neck Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Stevensville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. [Signature]</u> ADDRESS <u>Stevensville, Md.</u>		24a. REC'D BY REGISTRAR <u>DOET 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Powell</u> Last <u>Powell</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1959</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1899</u>		9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Powell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kelly</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-16-2179</u>		17. INFORMANT <u>Bessie Brown</u> Address <u>Merydel, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cat-onary Thrombosis</u> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN DEATH AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>10/27/59</u>			
EXAMINER'S NAME (Type) <u>Irvin G. Hoyt MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>OCT. 31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Barclay</u>				22d. LOCATION (City, town, or county) <u>Barclay Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar G. Lane</u>						ADDRESS <u>Church Hill Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. K...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



11811

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Russ</u> Last <u>Russ</u>		4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Cl.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Stevensville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
FATHER'S NAME <u>John Russ</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Robinson</u>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>0</u>	
17. INFORMANT <u>Lucie Russ Stevensville Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> DUE TO <u>Arteriosclerosis general + cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive vascular disease</u> (c) <u>hypertensive vascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jun 23</u> , 19 <u>59</u> , to <u>Oct 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 17</u> , 19 <u>59</u> , and that death occurred at <u>11 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.		ADDRESS (Street, city or town, state) <u>Stevensville, Md.</u> DATE SIGNED <u>Oct. 17, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER</u>		<u>Stevensville Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Stevensville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Rodwell, Catonsville, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>OCT 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Caring & House</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

— 1 2 3 4 5 6 7 8 9 10 11 12

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Md.		b. COUNTY		Q.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Queenstown				X Queenstown							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				1							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
Roy Ellwood Sterling								Oct. 20,		1959	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M	W			July 19, 1928		31 yrs.		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
None		-		Md.		U.S.A.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
William Sterling				Mayolia Mansfield							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT		Address					
No		-		Mrs. Robert Boone		Queenstown					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 519.0 Pneu monia , Lebar DUE TO (b) Pleurisy Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 day 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from July, 1957, to Oct., 1959, that I last saw the deceased alive on Oct. 20, 1959, and that death occurred at 11:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irvin B. Hoyt M.D. Queenstown, Md. 10/20/59 PHYSICIAN'S NAME (Type) Irvin G. Hoyt MD											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)			
Burial		Oct 23 - 1959		Christfields		Centerville Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Wm Earl Becking & Sons				Centerville Maryland		DATE OCT 22 59		Arthur L. Howe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11813 CERTIFICATE OF DEATH

11795

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>		c. LENGTH OF STAY IN 1b <u>3 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>1328 S. Hanover St.</u>	
3. NAME OF DECEASED (Type or print) <u>Veronica Mary Walker</u>		4. DATE OF DEATH <u>Oct 31</u> 19 <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Dickins</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>Mrs. Alma Clark</u>		Address <u>Stevensville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 19, 1959</u> to <u>Oct. 19, 1959</u> , that I last saw the deceased alive on <u>Oct. 31, 1959</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>		DATE SIGNED <u>10/31/59</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>		ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Nov. 4</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>	22d. LOCATION (City, town, or county) (State) <u>Stevensville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		24. REC'D BY REGISTRAR <u>Nov 3 '59</u>	
ADDRESS <u>Church Hill, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

[Faint, illegible handwriting throughout the page]